Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

State of Wyoming, Aging Division

Submission Date:	March 30, 2006

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
Wyoming is requesting the third renewal for waiver # 0236.

Application for a §1915(c) Home and Community-Based Services Waiver

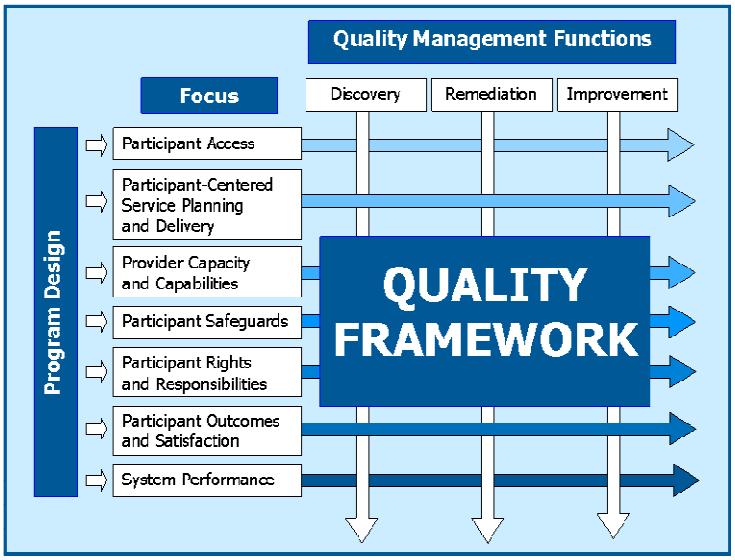
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

1. Request Information

A. The **State** of **Wyoming** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): Long Term Care Waiver (LTC/HCBS Waiver)

C. Type of Request *(select only one)*:

O	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
O	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
X	**Renewal (5 Years) of Waiver #**	#0236	
O	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

O	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
X	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: 7/1/06

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	O	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	O	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	X	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	O	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
X	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Long-Term Care (LTC/HCBS) Waiver serves people who are 19 years and older who meet the functional and financial criteria for nursing home. Services include Case Management, Personal Care Attendant with a consumer-directed option, Respite Care, Skilled Nursing, Adult Day Care, Home-Delivered Meals, Non-Medical Transportation and Personal Emergency Response System. There is also a consumer-directed option for personal care which includes the services of Care Coordinator and Self-Help Assistant

The goal of the program is to provide access to safe and appropriate services to Medicaid eligible, functionally impaired elderly and physically disabled citizens of the State of Wyoming.

The objectives are:

1) To minimize admissions to long term care institutions for people in this population who can be served at home.
2) To provide this population with access to appropriate social and health services to help them maintain independent living.
3) To provide for the most efficient and effective use of public funds in the provision of the needed services.
4) To allow communities flexibility in developing those services
5) To assure that safety and quality of the services are maintained.

The waiver is administered by the Aging Division of the Department of Health. The services are provided, under a Medicaid Provider Agreement, by entities within the communities that meet the provider qualifications for each service. The qualifications are verified by the Waiver Program Manger before a provider number is issued by the MMIS. Clients are offered a choice of all available providers for each service they require.

Individual services on a Plan of Care are approved by the Aging Division's waiver staff and are issued a prior authorization number for billing by the MMIS that limits the amount of services that can be billed to the amount that were approved.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

X	The waiver provides for participant direction of services. *Appendix E is required.*
O	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

O	Yes
x	No
O	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
X	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The Waiver Program Manager produces a monthly newsletter to communicate with the waiver providers and other interested parties about the waiver and waiver policy. The newsletter is distributed statewide, including the Reservation. The Aging Division also publishes a quarterly newsletter that is distributed to all entities within the state that deals with, or has interest in aging issues. Information about the renewal will be included in both newsletters along with the Aging Division's web information. The renewal document will post to the Aging Division's web site for public review and comments will be accepted.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Vereen
Last Name	Bebo
Title:	Home Care Services Program Manager
Agency:	Wyoming Department of Health, Aging Division
Address 1:	6101 Yellowstone Road, Suite 259B
Address 2:	
City	Cheyenne
State	WY
Zip Code	82002
Telephone:	307.777.7366
E-mail	vbebo@state.wy.us
Fax Number	307.777.5340

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	

Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	**Greg**	
Last Name	**Gruman**	
Title:	Administrator	
Agency:	Wyoming Division of Health Care Financing	
Address 1:	6101 Yellowstone Road	
Address 2:	Room 220	
City	Cheyenne	
State	WY	
Zip Code	82002	
Telephone:	307.777.6531	
E-mail	ggruma@state,wy.us	
Fax Number	307.777.6964	

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

X	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):		
	○	The Medical Assistance Unit *(name of unit)*:	
	X	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)	The Aging Division
○	The waiver is operated by		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*		

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

X	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	ACS is responsible to ensure that providers are qualified to render specific services under the Medicaid program by screening applicants of all provider types for state licensure, certification, and specialty board certification. The Office of Healthcare Financing reviews and approves the ACS procedures for provider enrollment. ACS is responsible to: • Receive requests for enrollment and mail all enrollment packets to providers • Process all provider enrollment applications, including reviewing returned

	packets for completeness and obtaining missing information. • Enroll providers eligible to provide medical assistance services • Notify providers of acceptance/rejection as a Wyoming Medicaid provider • Maintain and modify provider agreements, with State approval
O	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
X	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
	The Aging Division contracts with the individual counties for the Public Health Offices to perform the level of care evaluations.
☐	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Medicaid Office has a MMIS Contract Manager who assesses the performance of the MMIS contractor, ACS.
The Aging Division contracts with each individual county for the Public Health offices to perform the level of care assessments. The Waiver Program Manager and the Public Health Nursing Director assesses the performance of those contracts.

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Office of Healthcare Financing holds ACS contract meetings every two weeks to oversee activities and status of upcoming projects and address identified problems. MMIS Status meetings are held every other week to review project lists and monitor timelines for completion. Minutes of each meeting are kept and distributed to each person who attends the meetings. The MMIS contract manager in the Office of Medicaid communicates contract issues to the system users as necessary.

The contract with the Public Health Offices is monitored on an ongoing basis with the Waiver Program Manager doing a 10% desk audit of all LOC evaluations. There are data base edits in place that won't allow the submission of a new or renewal Plan of Care without a current LOC, or allow nursing home payments without the required LOC in place.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	X	X	☐	X
Assist individuals in waiver enrollment	X	X	X	X
Manage waiver enrollment against approved limits	X	☐	☐	☐
Monitor waiver expenditures against approved levels	X	☐	☐	☐
Conduct level of care evaluation activities	☐	☐	☐	X
Review participant service plans to ensure that waiver requirements are met	X	☐	☐	☐
Perform prior authorization of waiver services	X	☐	☐	☐
Conduct utilization management functions	X	☐	☐	☐
Recruit providers	X	☐	X	☐
Execute the Medicaid provider agreement	☐	☐	X	☐
Determine waiver payment amounts or rates	X	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	X	☐	☐	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
X	**Aged or Disabled, or Both**			
X	Aged (age 65 and older)			X
X	Disabled (Physical) (under age 65)	19 years		
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

X	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

X	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*
O	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:
	O [ ] %, a level higher than 100% of the institutional average
	O Other *(specify)*:
O	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
O	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one)*:
	O The following dollar amount: $ [ ]
	The dollar amount *(select one)*:
	O Is adjusted each year that the waiver is in effect by applying the following formula:
	O May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	O The following percentage that is less than 100% of the institutional average: [ ] %
	O Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	1450
Year 2	1450
Year 3	1450
Year 4 (renewal only)	1450
Year 5 (renewal only)	1450

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○	The State does not limit the number of participants that it serves at any point in time during a waiver year.
X	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1150
Year 2	1150
Year 3	1150
Year 4 (renewal only)	1150
Year 5 (renewal only)	1150

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○	**Not applicable**. The state does not reserve capacity.
X	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	For those being transitioned from nursing homes. The amount was determined based on the number of transitions over the past three years that were delayed because of waiting list issues. For emergency admissions. The amount was determined by the past experience with those on the waiting list that were in desperate need of services to avoid institutionalization. Criteria will be developed for both instances to avoid the potential of circumventing the waiting list.
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose: Institutional transition Capacity Reserved	Purpose: Emergency admissions Capacity Reserved
Year 1	2%	1%
Year 2	2%	1%
Year 3	2%	1%
Year 4 (renewal only)	2%	1%
Year 5 (renewal only)	2%	1%

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

X	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

X	Waiver capacity is allocated/managed on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

First come, first served statewide selected from a list of functionally and financially eligible applicants.

1) The Case Manager of the applicant who comes to the top of the list is notified by phone. A new LT101, if the previous one is more than 45 days old, a current Client Choice of Service, and an updated Plan of Care are requested. The Case Manager is expected to respond with the paperwork to initiate waiver services, or call the Aging Division explaining any delay, within one week.
2) Consumer-Directed Care applicants are allowed time to complete Central Registry checks and provide payroll information to the fiscal agent.
3) Those applicants who are not ready to receive waiver services are allowed to write a letter requesting they be placed at the bottom of the waiting list.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

X	§1634 State
O	SSI Criteria State
O	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
X	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
☐	Optional State supplement recipients		
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	O	100% of the Federal poverty level (FPL)	
	O	%	of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy		
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*			
O	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.		
X	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*		
	O	All individuals in the special home and community-based waiver group under 42 CFR §435.217	

	X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:			
		X	A special income level equal to (select one):		
			X	300% of the SSI Federal Benefit Rate (FBR)	
			○	%	of FBR, which is lower than 300% (42 CFR §435.236)
			○	$	which is lower than 300%
		☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
		☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
		☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
		☐	Aged and disabled individuals who have income at: *(select one)*		
			○	100% of FPL	
			○	%	of FPL, which is lower than 100%
		☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

X	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
	X — Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
	○ — Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- X — The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - X — The special income level for institutionalized persons *(select one):*
    - X — 300% of the SSI Federal Benefit Rate (FBR)
    - ○ — % — of the FBR, which is less than 300%
    - ○ — $ — which is less than 300%.
  - ○ — % — of the Federal poverty level
  - ○ — Other (specify):
- ○ — The following dollar amount: $ — If this amount changes, this item will be revised.

○	The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
X	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
X	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

X	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300% of the FBR
  - ○ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The following standard under 42 CFR §435.121
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
- ○ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following dollar amount: $ [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ ____ % of the FBR, which is less than 300%
    - ○ $ ____ which is less than 300%.
  - ○ ____ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- X Not applicable

iii. Allowance for the family *(select one)*:	
○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
X	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○ %	of the FBR, which is less than 300%	
		○ $	which is less than 300% of the FBR	
	○	%	of the Federal poverty level	

	○	Other (specify):	
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable		

iii. Allowance for the family *(select one)*

○	AFDC need standard	
○	Medically needy income standard	
○	The following dollar amount: $	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:	
○	Other (specify):	
○	Not applicable (see instructions)	

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**	
○	SSI Standard
○	Optional State Supplement standard
○	Medically Needy Income Standard
○	The special income level for institutionalized persons
○	% of the Federal Poverty Level
○	The following dollar amount: $ If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:
X	Other (*specify*)**:**
	300% of the SSI Federal Benefit Rate
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*	
X	Allowance is the same
○	Allowance is different. Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
○	The State does not establish reasonable limits.
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	1 plus Case Manage-ment	
ii.	**Frequency of services**. The State requires *(select one)*:	
	X	The provision of waiver services at least monthly
	O	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

O	Directly by the Medicaid agency
O	By the operating agency specified in Appendix A
X	By an entity under contract with the Medicaid agency. *Specify the entity*:
	Public Health Nursing
O	Other (*specify*):

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered Nurse employed by a Public Health Agency

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The LT101 is used to determine medical necessity for both nursing home and waiver. It is conducted in an identical manner, with the same requirements, for either placement.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

X	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
O	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The referral of the client seeking waiver services is to the local Public Health Agency. A Public Health Nurse evaluates the client in their home within three working days using the LT101. If the client makes the required 13 points, or above, they are referred to the local Department of Family Services Office for the financial determination. At the present time there is a waiting list for waiver services. If the waiting time exceeds 45 days another LT101 is done before a Plan of Care is approved.

Reevaluations are done, by the Public Health Nurse, within the 30 days prior to the expiration of the current Plan of Care

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

O	Every three months
X	Every six months
O	Every twelve months
O	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

X	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
O	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

Computer generated lists of those recipients who are due to be reevaluated are sent out, by county, to the Public Health Agency and the specific Case Manager the month before the current Plan of Care expires. Renewal Plans of Care are not approved and entered into the system without a current (less than 45 days old) level of care reevaluation.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The level of care evaluations and reevaluations are maintained in files in the Division of Aging, within the Case Managers files and by the Public Health Agency. They are also entered electronically into the MMIS system. They are being maintained for 6 years beyond the date of discharge.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Client Choice of Service form (HCBS-1), which includes the choice of community or institutional care, an explanation of the client's fair hearing rights and a statement that they have been a participant in the care planning process and agree with the services selected (to be submitted with the electronic Plans of Care), is explained to the client by the Case Manager before the Plan of Care is completed. It is signed by the client and the Case Manager and copy is given to the client and a copy is submitted with the Plan of Care, as well as maintained with the Case Manager's client records. This form is completed with admission to the waiver and with every Plan of Care renewal.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Client Choice of Service (HCBS-1) forms are maintained in files in the Aging Division and in the Case Managers records.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Access is not denied and every effort is made to provide translation services for limited English proficient persons. Community colleges have provided translations services in the communities where they are located and the Department of Health has an Office of Minority Health which is available to help coordinate translation services in the individual communities. Family members also provide assistance when possible. Waiver materials will be provided in other languages, if requested.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	X	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	X	Personal Care Attendant
Adult Day Health	X	Adult Day Care
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	X	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
○	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Skilled Nursing
b.	Home Delivered Meals

c.	Non-Medical Transportation
d.	Personal Emergency Response System
e.	
f.	
g.	
h.	
i.	

Extended State Plan Services *(select one)*

X	Not applicable
O	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(select one)*

X	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
O	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	X	Care Coordinator
Financial Management Services		

Other Supports for Participant Direction *(list each support by service title)*:

a.	Self-Help Assistant
b.	Care Coordinator
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☐	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Home Health agencies, Public Health agencies, Community Based In-Home Services providers, Nurse Practioners and Master's prepared Social Workers. Independent Living Centers (for Consumer-Directed Care Program)

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

○	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
X	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

X	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	The Department of Family Services maintains a Central Registry of abuse, neglect or exploitation of children or vulnerable adults. All Self-Help Assistants used on the Consumer-Directed option for personal care must be screened. Their information is not forwarded to the Fiscal Agent for entry into their payroll system unless the successful Central Registry check is included. Adult Day Care Facility Rules (Aging Division, Chapter 7) require that all staff must complete a Central Registry check or Board of Nursing registry check (if applicable). Personal Care providers are state licensed or Medicare certified agencies and the services must be provided by CNAs. The CNAs are checked against the Board of Nursing Registry and a Central Registry check is done as per the Rules for Program Administration of Home Health Agencies (Aging Division, Chapter 9). Evidence of proper screening is checked as part of the yearly on-site provider visits by the Waiver Program Manager.
○	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

X	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
○	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies	☐	☐	☐	☐
Physical environment	☐	☐	☐	☐
Sanitation	☐	☐	☐	☐
Safety	☐	☐	☐	☐
Staff : resident ratios	☐	☐	☐	☐
Staff training and qualifications	☐	☐	☐	☐
Staff supervision	☐	☐	☐	☐
Resident rights	☐	☐	☐	☐
Medication administration	☐	☐	☐	☐
Use of restrictive interventions	☐	☐	☐	☐
Incident reporting	☐	☐	☐	☐
Provision of or arrangement for necessary health services	☐	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

X	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
X	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	Relatives, except a spouse, may be employed by the Consumer-Directed client as a Self-Help Assistant to provide services and amount of services included on an approved Plan of Care designed and submitted by a Care Coordinator based on documented needs. The Self-Help Assistant completes time sheets signed by the consumer and presented to the Fiscal Agent for payment. The Medicaid Program Integrity Program randomly request records to verify the documentation of paid claims and recovery is made if the documentation does not support the paid claim.
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Potential providers are instructed to contact the MMIS Provider Relations to obtain the Medicaid provider enrollment packet and they are offered any assistance necessary to complete and submit the information. The Medicaid provider enrollment packets are also available on the Equality Care/ACS website.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Case Management

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State Plan services, as well as other needed medical, social, educational and other services, regardless of the funding source. Case Managers shall be responsible for designing and submitting the Plan of Care and the required documentation, upon admission and renewal, for approval and the ongoing monitoring of the provision of services included in the Plan of Care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The Case Manager service is billed at a daily rate and cannot exceed the number of days in the month. They are not allowed to bill for days the client is not in the home, e.g., in the hospital, in the nursing home, or out of town.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Masters prepared social workers or nurses		Home Health Agencies,	
			Community Based In-Home Services Providers	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	State licensure: WS33-21-127	Medicare Certification	HCBS Standards and experience (modifying experience in community health setting from three years to one year for licensed nurses)
Community Based In-Home Services		State Certification	State approved program, HCBS Standards and experience
Individual Provider	Licensed MSW	Certified Advance Practice Nurse	Three years experience as an LTC/HCBS Waiver Case Manager

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agencies	**Office of Healthcare Licensing and Survey**	**1 – 3 years**
Community Based In-Home Services Programs	**Division of Aging**	**Ongoing**
Individual Providers	**Board of Nursing** **Mental Health Licensing Board (MSW)**	**Every 2 years** **Every 2 years**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Skilled Nursing
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Services listed within the Plan of Care which are within the scope of the Wyoming Nurse Practice Act and are provided by a licensed nurse and are not covered as stand alone services under the home health Medicare or Medicaid benefit.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Home Health Agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	RN, LPN (under the supervision of an RN WS33-21-120		HCBS Standards, State Rules and Regulations

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	**Office of Healthcare Licensing and Survey**	**Every 1 – 3 years**

Service Delivery Method				
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Personal Care Attendant

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Assistance with eating, bathing, dressing, personal hygiene and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. This service may also include such housekeeping chores as bed making, dusting, vacuuming, and laundry, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal Care attendants will be supervised by a registered nurse, licensed to practice nursing in the state, or a licensed practical nurse, under the supervision of a registered nurse, as provided under State law. The frequency of the supervision is as indicated by agency policy, but at least every 60 days.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Home Health Agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency		CNA WS33-21-127	OBRA 1987, State Board of Nursing, HCBS Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	**Office of Healthcare Licensing and Survey**	**Every 1 – 3 years**

Service Delivery Method

Service Delivery Method*)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Respite Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or the need for relief of those persons normally providing the care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Home Health Agencies
				Community Based In-Home Services Program (grant to mostly senior centers)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency		CNA WS33-21-127	OBRA 1987, State Board of Nursing, HCBS Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	**Office of Healthcare Licensing and Survey**	**Every 1 – 3 years**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Adult Day Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services furnished on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals a day).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Licensed Adult Day Care Facilities

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Care Facilities	State Licensed WS35-2-901-904		State Rules and Regulations

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Care Facilities	**Office of Healthcare Licensing and Survey**	**yearly**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Home –Delivered Meals
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Meals to be delivered to the home of the resident or to Adult Day Care.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limited to 2 meals per day.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Meals-on-Wheels Programs, Senior Centers
				Hospitals, Nursing Homes
				Restaurants
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Meals-on-Wheels Programs			HCBS Standards, State Rules and Regulations (WS33-1-240)
Hospitals, Nursing Homes			HCBS Standards, State Rules and Regulations
Restaurants			HCBS Standards, State Rules and Regulations

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Non-Medical Transportation
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified in the Plan of Care. This service is offered in addition to medical transportation required under §42 CFR 431.53, under the State Plan, defined at §42 CFR 440.170(a) and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's Plan of Care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	☐	Agency. List the types of agencies:
	Bus, private vehicle, taxi, etc.			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Bus, private vehicle, taxi, etc.	Driver's license WS31-7-106		UMPTA, HCBS Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Bus, private vehicle, taxi, etc.	**Waiver Program Manager**	**Initial**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification					
Service Title:	Self-Help Assistant				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope)**:**					
Attendant chosen by the client on Consumer-Directed Care. May be certified or non-certified, may be a family member with the exception of the spouse. Consumer is responsible for recruiting, interviewing, hiring, training, supervising and terminating the Self-Help Assistant. The Self-Help Assistant duties include those tasks that the consumer is unable to do for themselves because of a disability. Central Registry check is required. When CNAs are selected as Self-Help Assistants they must be supervised by a nurse.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
. At least two-thirds of the attendant time must be hands-on personal care.					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	☐	Agency. List the types of agencies:
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			Consumer determined

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Self-Help Assistant	**Consumer**	

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	☐	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Personal Emergency Response System

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

PERS is an electronic device which enables certain individuals at high risk for institutionalization to secure help in an emergency. The individual may also wear a "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response once a "help" button is activated. PERS services are limited to those individuals who live alone, or are who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Hospitals, nursing facilities, senior centers, other agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Hospitals, nursing facilities, senior centers, other agencies			HCBS Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Fiscal Management Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

This service provides finance, employer, payroll and related functions for the consumer. These services assure that the funds to provide Consumer-Directed services approved on the Plan of Care are managed and paid appropriately as authorized.

The fiscal management services provider will obtain an Employer Identification Number (EIN)from IRS to operate on behalf of the consumer to operate on behalf of the consumer to withhold, report and pay federal income and unemployment taxes and ensure that all federal and state tax law (if applicable) and labor law requirements are met.

The Fiscal Agent will:

- Enroll consumer in FMS and obtain authorization from the IRS to serve as the agent for the consumer
- Prepare and distribute an application package of information that is clear and easy to understand for the consumer hiring their own staff to understand and follow
- Provide needed counseling and technical assistance regarding the role of the Fiscal Agent to the consumer and others
- Process employment application package and documentation for prospective individual to be employed
- Verify Central Registry checks on prospective consumer-employed caregivers
- Establish and maintain record for each individual employees and process all employment records
- Withhold, file and deposit FICA, FUTA, and SUTA taxes in accordance with Federal IRS and DOL, and state rules
- Process all judgments, garnishments, tax levies or any related holds on a consumer-employed caregiver as may be required by local, state or federal laws
- Generate and distribute IRS W-2s and/or 1099s, wage and tax statements and related documentation annually to all consumer-employed caregivers who meet the statutory threshold earning amounts during the tax year by January 31st
- Withhold, file and deposit federal income taxes in accordance with federal IRS rules and regulations
- Act on behalf of the consumer receiving services for the purpose of payroll reporting
- Distribute, collect and process caregiver time sheets as summarized on payroll summary sheets completed by the consumer
- Prepare payroll checks bi-weekly, sending them to the consumer
- Generate payroll checks in a timely and accurate manner, as approved in the consumer's Plan of Care and current Prior Authorization Number, and in compliance with all state and federal regulations pertaining to "domestic service" workers (as defined by IRS)
- Generate utilization reports quarterly for consumer's Care Coordinator records

The Fiscal Agent will also establish and maintain all consumer records with confidentiality, accuracy and

appropriate safeguards, respond to calls from consumers and employees regarding issues such as withholdings and net payments, lost or late checks, reports and other documentation, file claims through the MMIS for consumer services and prepare checks for consumer-employed caregivers and generate service management and statistical information and reports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Fiscal Management Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency			HCBS Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	**Waiver Program Manager**	**Upon enrollment and as necessary**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Care Coordinator

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Assess the consumer's ability to direct their own care, assist the consumer to learn how to direct their own care, assist the consumer in planning their care and submits the Plan of Care for approval. At least one face-to-face visit is required each month to monitor the provision of services, assess the client's continuing ability to self-direct, assess the need for and access to Medicaid State Plan services and other community services and monitoring ongoing Medicaid eligibility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The Care Coordinator service is billed at a daily rate and cannot exceed the number of days in the month. They are not allowed to bill for days the client is not in the home, e.g., in the hospital, in the nursing home, or out of town.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Independent Living Centers
				Home Health Agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Independent Living Centers			HCBS Standards
Home Health Agencies	RN, LPN WS33-21-120	Social Worker	HCBS Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agencies	**Office of Healthcare Licensing and Survey**	**Every 1 - 3 years**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*
X	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
	Dollar amount of each individual Plan of Care is capped at $900/month. Any Plan of Care exceeding that amount needs the verbal and written approval of the Waiver Program Manager. Approval of a Plan of Care exceeding that amount is based on a decision tree that includes: **a) the client diagnosis/need,** **b) safety of the client,** **c) current Plan of Care cost,** **d) are the increased services achieving nursing home diversion,** **e) the care situation within the home/availability of other services,** **f) the expected time frame of the added services.** **This process applies to any services that push the total cost of the services over $900/ month.** **Plans of Care can be amended at any point of the Plan of Care period if the client's needs change, but each amendment that allows the total to exceed $900/month also need verbal and**

	written approval. **Plans are to develop a log or tracking system with in the waiver data base to allow tracking of the cases that exceed the cap.** **The client is notified by the Case Manager when the approval is given for the additional services.**
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
X	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	All Plans of Care are approved by the state office and are prior authorized. Clients are provided with Client Evaluations accompanied by a stamped self-addressed return envelope every six months. Any Plan of Care that total over $900/month needs the approval of the waiver program manager. On-site visits are made to each provider once a year that involve record reviews and client visits. Case Managers shall not function as legal guardian, power of attorney, or as financial representative for eligibility determination for any waiver clients managed by the agency that employs them.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Plan of Care development process is as follows:

(a) The Plan of Care is developed within five (5) working days after notice that the client has been determined financially eligible the Case Manager meets with the client and any person/persons the client requests and any applicable members of the multi-disciplinary team.

(b) The overall objectives and the treatment plan are discussed. The various waiver forms are discussed and signed as appropriate. Using the LT101 and the Service Care Plan prepared by the Public Health and discussion with the client goals are established.

(c) It is determined what services the client needs and which ones are available as waiver services. The Case Manager also helps determine if there are needs that are not available as waiver services and assists the client with other options. The client is offered the choice of the providers for each of the service to be included in the waiver Plan of Care and, where appropriate, the option of Consumer-Directed care.

(d) The Case Manager informs the client of their duties, e.g., the monthly waiver visit to the client's home, the communication with the other providers and their monitoring of the provision of the other services on the Plan of Care to ensure the appropriate, timely provision of services.

(e) The Case Manager provides a Provider Duty Form (HCBS-6) to all of the other providers included in the Plan of Care. This form includes the Plan of Care approval date, the requested service, frequency and amount and reimbursement rate. The other provider is required to sign an agreement to provide the requested service and return a copy to the Case Manager, which is kept in the Case Manager's file.

(f) Each individual provider is responsible for assuring the delivery of the service as specified on the Plan of Care and for furnishing the Case Manager with verification of the service amounts.

(g) The Plan of Care can be amended at any time during the life of the Plan. The services are all prior authorized so the Plan needs to be amended when services change so the

provider will be able to bill. Plans of Care are renewed every six (6) months. An original Plan of Care can begin on any day of the month and the first on has as many days as remain in the month. All Plans end at the end of the month and all renewal begin at the first of a month. At the first of each month our office sends a list to each Case Manager listing all of the renewals they have due for the next three months. We also send out lists to the Public Health Offices listing all the renewals that are due within their county for the next three months so they can do the LT101s. We accept renewal Plans of Care any time during the month before they are due. If they are received after the 25th of the month we accept them, but it is an error that is reflected on the error log. A report is run after the first of the month to identify any Plan of Care that has not been received.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Currently the Case Manager addresses risk potential in their initial visit and in the ongoing visits as necessary, but there is no standard of documentation. The electronic Plan of Care is being modified to include identified risks and a risk assessment tool will be developed and the process for documentation and follow-up will be established.

Case Management and Personal Care Attendant services are provided by agencies so the backup is handled within the agency. The Consumer-Directed Program requires a backup person who has had a Central Registry check before the client is approved for the program.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

When the level of care evaluations are done the Public Health Nurse offers the client a choice of all qualified Case Management providers and their choice is placed at the top of the LT101 form and a copy of the LT101 goes to the selected Case Manager as well as information from the Department of Family Services when the financial determination is completed. The Case Manager offers a complete choice of all service providers and the client indicates his/her choice of each by circling the choice on the list. This choice is maintained in the Case Manager's client record.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Paper Plans of Care are submitted to the Aging Division by fax accompanied by the required attachments (Level of Care Evaluation, Client Choice of Service, notice of financial eligibility, and face sheet on new admissions; Level of Care Evaluation and Client Choice of Service of renewals). The Plans are checked for completeness, and appropriateness of services, entered into the database for transmission to the MMIS and stamped with the official "HCBS" stamped and initialed and

dated. Electronic Plans of Care are submitted through a CITRIX environment to the Aging Division. The rest of the attachments are faxed. The same approval process is followed and the approval is done electronically and the Plan is transmitted to the MMIS. Electronic Plans of Care are printed off for the Case Manager's file, the client and the Aging Division.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

O	Every three months or more frequently when necessary
X	Every six months or more frequently when necessary
O	Every twelve months or more frequently when necessary
O	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

X	Medicaid agency
☐	Operating agency
X	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The monitoring the implementation of the Plan of Care and the participant health and welfare is done by the Case Manager. The Case Manager is required to make at least one face-to-face visit a month and documents the satisfaction with the waiver services, as well as the client's well-being. The waiver program manager makes yearly on-site visits and does record reviews and client visits.

b. Monitoring Safeguards. *Select one:*

O	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	The waiver program manager makes yearly on-site visits and does record reviews and client visits.

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

X	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
X	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Consumers on the LTC/HCBS Waiver in Wyoming have the availability of Consumer-Direction as an option for personal care services. Each client choosing this option must be able to direct their own care, which is assessed by the Care Coordinator at the time of application for the waiver and as frequently as indicated thereafter. Consumers may choose to self-direct at the time of application or make the decision at any time while on the waiting list, or at any time after they begin receiving services. They can also change from Consumer-Directed Care back to agency provided services at any time, with a submission of an amendment to their Plan of Care. Each consumer has a Care Coordinator that assists the consumer to learn how to direct their own care, and how to plan their own care. If necessary, they help the client to write newspaper ads to recruit applicants for Self-Help Assistants, help with a job description for their attendants, help develop a schedule for their attendants, help with guidance on what records to keep, and advise them on how to supervise, provide constructive feedback, and terminate their attendants. The Care Coordinators are required to make a face-to-face visit each month to monitor the provision of services, assess the consumer's continuing ability to self-direct, assess the need for and access to Medicaid State Plan services and other community resources, and monitoring ongoing Medicaid eligibility.

The Consumer-Directed Program has a fiscal agent who is a Medicaid waiver provider who processes the payroll portion of the program, paying the Self-Help Assistants chosen by the consumer based on time sheets counter signed by the consumer.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

X	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

X	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
X	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:
	Consumer-Direction is offered as an option to the Personal Care Attendant service. The client must be capable of directing their own care and at least 2/3 of the attendant time needs to be hands-on personal care.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Care Coordinator is responsible to inform and educate the consumer. The Independent Living Centers have developed a manual for their consumers that contains information about recruiting, interviewing and taking applications for their Self-Help Assistants; guides for scheduling, creating job descriptions, and to provide determine if they are receiving quality services; information on how to direct their attendants, how to verify the payroll records and how to problem-solve. Much of this process is accomplished while the consumer is still on the waiting list. The consumers are informed of the choice between agency provided care and Consumer-Direction as well as their ability to change their minds at any time.

The fiscal agent has recently redesigned the payroll sheets to better satisfy the requirements for Medicaid when records are required to verify paid claims. They are conducting instructional meetings across the state and are inviting the consumers, their attendants and the Care Coordinators. This has proved to be a wonderful forum for the consumers to learn more about the process and strengthen their abilities to direct their own care. The fiscal agent also provides the consumer with a packet of information with detailed instructions about submitting time sheets and timelines along with a toll free number for assistance. The fiscal agent also has a dedicated account manager for the Wyoming program who is available to consumers, their Self-Help Assistants and Care Coordinators to answer

questions and help as needed on payroll issues. As consumers go on the program they are furnished with a well-designed, easy to follow packet of information about the fiscal agent's role in the program and what the consumer responsibilities are.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

X	The State does not provide for the direction of waiver services by a representative.	
○	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	☐	Waiver services may be directed by a legal representative of the participant.
	☐	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Self-Help Assistant	X	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

X	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	☐	Governmental entities
	X	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

X	FMS are covered as the waiver service entitled as specified in Appendix C-3.	Financial Management Services
○	FMS are provided as an administrative activity. *Provide the following information:*	

i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

☐	Assist participant in verifying support worker citizenship status
☐	Collect and process timesheets of support workers
☐	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
☐	Other *(specify):*

Supports furnished when the participant exercises budget authority:

☐	Maintain a separate account for each participant's participant-directed budget
☐	Track and report participant funds, disbursements and the balance of participant funds
☐	Process and pay invoices for goods and services approved in the service plan
☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
☐	Other services and supports *(specify)*:

Additional functions/activities:

☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
☐	Other *(specify):*

iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and

		assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

E. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

X	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
	Care Coordinators for the Consumer-Directed Program are responsible for assessing the consumer's ability to direct their own care and providing information and instruction to help them acquire the necessary skills, including, but not limited to, the following: 1) How to prepare a job description based on the consumer's needs and the program guidelines 2) How to recruit attendants, including how to write ads, where to post them, what to look for in the applications, how to set up interviews, how to conduct interviews, how to select attendants with the desired qualifications/attributes, etc. 3) How to obtain Central Registry checks and identification information for the fiscal agent and how to do the required time sheets 4) How to schedule the attendant time and stay within the prior authorized amount 5) How to prepare time sheets and verify the hours worked and submit them to the fiscal agent to meet the time frames for payroll 6) How to evaluate the service provided and furnish constructive criticism 7) How to terminate staff 8) What records to keep and for how long The Care Coordinator visits monthly to assess the provision of services and to assess the consumer's continuing ability to direct their own care and to assess the need for and access to Medicaid State Plan services and other community resources. It is also the Care Coordinator's responsibility to submit the required paperwork to the Aging Division for approval
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

E. Independent Advocacy *(select one)*.

○	**Yes**. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

X	**No.** Arrangements have not been made for independent advocacy.

E. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Consumer-Direction is an option for Personal Care Attendant services so when the client elects to terminate the Consumer-Direction they are offered the choice of Case Management agencies and Personal Care providers. The transition is accomplished by a Plan of Care amendment.

E. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

When the client is found to no longer capable of directing their own care the Care Coordinator assists in securing provider managed care. The Care Coordinator monitors the situation until the new providers are on board.

E. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	232	
Year 2	240	
Year 3	245	
Year 4 (renewal only)	252	
Year 5 (renewal only)	260	

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
X	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

X	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
X	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The client may pay or they may require the applicant to pay.
X	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
X	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
X	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Client Choice of Service form also includes the client of their fair hearing rights and the instruction on how to request one. This form is completed on admission and at every renewal (every six months). When a client does not qualify for the program on the level of Care evaluation they are also given a Denial Letter that explains their hearing rights. In the event of a fair hearing request, the waiver services continue until the hearing resolution.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

X	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
○	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

When the client does not qualify on the level of care evaluation they are informed in the Denial Letter of their right to reconsideration as per Wyoming Medicaid Rules, Chapter 22, Section 8. The client must request a reconsideration in writing, within 30 days of the initial evaluation to the Waiver Program Manager and the program manager contacts the relevant agency and requests that another evaluation be done by a different nurse. Section 9 of the above mentioned rule addresses the process of requesting an administrative hearing. It must be requested within 30 days of the adverse action.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

○	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items).*
X	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Adult Protective Services Act, WS35-20-101 – 116 requires that any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused neglected, exploited or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the Department of Family Services. The report may be orally or in writing. The Adult Protective Services Manual requires that private interviews with the alleged perpetrator must occur within three (3) calendar days of accepting the report. Events that trigger investigations require immediate (no later than within 24 hours) response. Self-neglect is assessed, not investigated.

The Office of Healthcare Licensing and Survey also investigates complaints that are reported directly to their office or referred by the State Long Term Care Ombudsman as per the Agreement between the Secretary of the U.S. Department of Health and Human Services and the State of Wyoming dated June 18, 1985. Timelines are described as appropriate depending upon the seriousness of the allegations. (Wyoming Department of Health, Aging Division Rules for Program Administration of Home Health Agencies, Chapter 9)

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

A packet is being developed in conjunction with the Community Based In-Home Services Program, the National Family Caregiver Program and Adult Protective Services. It will be designed for the Case Managers to use in face-to-face discussions with the clients. The packet will include the definition of abuse, neglect and exploitation and how to recognize if it is happening to them, and how to report it. There will be a discreet magnet, or other item that can be kept in plain sight, with the reporting phone number. The Case Manager will assess the client's situation at each Case Management visit and do ongoing instruction and intervention as necessary. We are working with the Suicide Prevention Specialist to include the recognition of depression and how to get help. This project is scheduled to be launched at the annual Case Manager Conference in April.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Adult Protective Services arm of the Department of Family Services, the Office of Healthcare Licensing and Survey and law enforcement receive the reports of critical events or incidents. (W.S. 35-20-102 – 116).

Reports are made to the local APS worker at the Department of Family Services. The case is immediately also referred to law enforcement, if appropriate. The investigation is begun within 24 hours and a Risk Assessment must be completed within three days, including the interview with the vulnerable adult and all members of the support system. The initial contact with the vulnerable adult is attempted immediately and must be accomplished within 24 hours, with the help of law enforcement, if necessary. The APS caseworker administers the Risk Assessment a second time later in the case to assist in deciding when to close the case. Reports are evaluated within the local APS unit and are shared with the appropriate entities on a need-to-know basis.

APS employs a structured decision making process to determine response priority which includes the Risk Assessment and other optional assessment tools as well as the caseworkers professional judgment and supervisory guidance. The State Social Service Consultant for Adult Protection is often involved as a consultant. The priority of response is placed in one of the following categories:

1) Immediate referral to law enforcement
2) Immediate response (in person contact) by DFS
3) Investigation is initiated within 24 hours, in person within three (3) calendar days

A statement of Allegations advises the person(s) suspected of abuse, neglect, abandonment or exploitation of a vulnerable adult of an investigation by DFS. It must be completed and deliver to the person suspected of the mistreatment within seven (7) calendar days of the acceptance of the case.

An adult protection case is closed when:

1) Investigation or assessment is complete
2) Indicated protective services have been concluded; and
3) Necessary referrals and, acceptance of the referral, to other agencies have been made.

The caseworker, in consultation with the APS supervisor, is responsible for determining what follow-up is need in each case investigated.

Upon completion of an investigation, DFS prepares a written determination as to whether a vulnerable adult was abused, neglected, abandoned or exploited based on the evidence gathered during the investigation. A Notice of Conclusion is mailed to the alleged perpetrator, the professional reporter, who filed the complaint, the vulnerable adult or their guardian, law enforcement and all agencies who were notified of the initial allegations within seven (7) calendar days of the conclusion of the investigation. Each substantiated report of abuse, neglect, abandonment or exploitation of a vulnerable adult is entered and maintained within the Central Registry of vulnerable adult protection cases and the perpetrator is notified in writing.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Adult Protective Services agency oversees critical incidents and events. At the present time the communication system about those events that concern waiver clients is informal and is usually conducted by phone. A protocol is being developed drawing on the partnerships that have been established with APS, the Office of Healthcare Licensing and Survey, and the Long Term Care Ombudsman and using the processes the waiver providers already have in place. Tracking, trending, and reporting capabilities will be available in the final product, along with establishing a formal oversight function with the frequency of oversight specified..

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed.

a. Applicability. *Select one:*

X	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(do not complete the remaining items)*	
○	This Appendix applies. Check each that applies:	
	☐	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☐	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete items G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
X	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

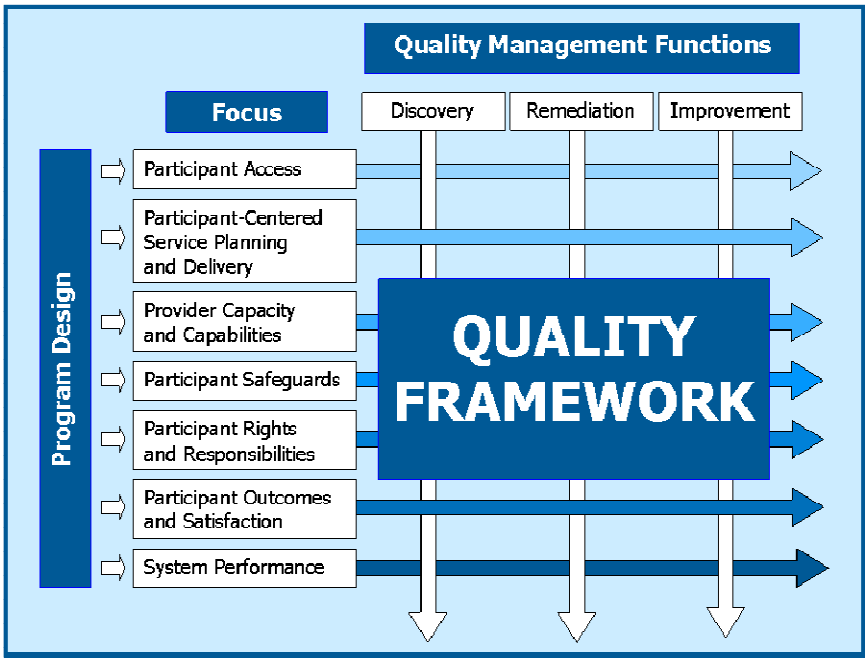
ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.**

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

As much as possible the following Quality Management Strategy will be also be used for Waiver # 0369, The Assisted Living Facility Home and Community-Based Waiver

QMS Element H.1: Waiver Assurances

1) Level of Care Determination

The instrument used to determine the level of care for the LTC/HCBS Waiver is the LT101 which has been used to determine the level of care for nursing homes in Wyoming since 1989. It is preformed by the local Public Health Nurses under contracts with the Aging division. The contract requires that the assessment is preformed within three (3) working days of the referral and that the appropriate copies are distributed within one (1) working day of completion. Extensions may be granted if the Public Health Office is unable to complete the evaluation in a timely manner because of an unavoidable circumstance, e.g., inclement weather, a one nurse office, etc. The LT101 is done at the time of referral for eligibility. If it is more than 45 days before waiver services are initiated another one is done when the applicant comes to the top of the list. Reevaluations are done every six (6) months after admission to the waiver at the time of the Plan of Care renewal. Lists of those that are due are sent out to the appropriate Case Managers and to the Public Health Offices the first of the month before the renewal is due. New or renewal Plans of Care are not entered into the system without a current (less that 45 days old) LT101. 13 points are required to qualify for either nearing home or waiver services. If an evaluation results in less than 13 points a Denial Notice is given to the client informing them of their reconsideration and fair hearing rights and instructions on how to request them. The Waiver Program Manager is also responsible for the LT101 program. Public Health Nurses have been trained by compressed video and the training is available on video tape. New nurses who are learning to do the assessments watch the video and are further trained by nurses who are experienced in doing them. Training letters are issued as individual problems arise and the HCBS Newsletter is used to disseminate information as well. The Waiver Program Manager encourages phone calls and often discusses individual problems with the completion of the assessment. A provider manual has been made available to each nurse doing the LT101s across the state. This manual is scheduled to be updated in the near future. The Waiver Program Manager does a desk review of 10% of all the LT101s that are done, both for nursing home and the waivers. It is planned to develop a tracking process to determine the length of time between the application and the completion LT101, which will also include the ability to differentiate between waiver clients and nursing home residents.

2) Plan of Care

Plans of Care are renewed every six (6) months and all are approved by the waiver staff and prior authorized so that the MMIS does not pay any claims that are not approved on the individual Plans of Care. An error log has been developed that tracks errors on submitted Plans of Care that need action by the Case Manager before they can be entered into the system. Copies of each Case Manager's errors are sent to their supervisor at the beginning of each month to provide information that the supervisors can use as tools to improve Case Manager performance and track outcomes.
We now graph the total number of errors quarterly and it is planned that we add trend lines and comparisons to the rest of the state to the supervisor's monthly reports. The first month the report showed 143 errors and the latest shows 27 errors. Future plans include a tracking system to focus on errors that are "not resolved" and use the information to provide training and assist the supervisors to determine where the problem areas are. We have also developed the capability of submitting new and renewal Plans of Care electronically. We still accept paper submissions. At this point 74 % of all client Plans of Care are being submitted electronically (see Appendix D-1:3, g.). The electronic format

contains edits that reduces the opportunity for errors on the submitted Plan of Care. The process is faster and requires less staff time to enter the Plans of Care into the system. Future plans include adding a field for identified risks.

Amendments to the Plan of Care are possible at any time the client's need change. There is a $900/month cap on waiver services. This limit can be exceeded with verbal approval of the Waiver Program Manager based on a decision tree as described in Appendix C-4.

A "claims" field has been added to the waiver data base which allows the Waiver Program Manager to track paid claims on each waiver client and also calculates the percent of the planned services that have been utilized. This function has been installed on the tablet computer so that each provider's information is available for retrieval while doing on-site visits. Still planned is a reporting program that can analyze the information.

The Waiver Program Manager makes on-site visits to the providers once a year to monitor and ensure that the planned waiver services are being delivered as approved and to assess the quality of the services. These visits include record reviews and client home visits. A new on-site visit review form is being developed that will allow the agencies deficiencies and best practices to be identified, tracked and trended. Plans also include redesigning the Case Manager agency documentation to involve more supervisor interaction. It is envisioned that documentation will include a quarterly report that includes a compilation of number of clients, number of client visits, phone calls, incidents and resolutions and non-provided services and the reason. These reports would be submitted electronically, quarterly, so that data could be compiled from them and the Wavier Program Manager will be able to discuss the agency performance at the time of the on-site visit.

The client evaluation process is being redesigned. The form sent to the client with every renewal (six months) will have circles that are darkened and will be read by a scanner and downloaded into an Access program that will tabulate the results be available for queries on client satisfaction.

3) Qualified Providers

Waiver providers are enrolled by the MMIS. Before assigning a provider number the enrollment packets are routed to the Waiver Program Manager to verify the provider qualifications and indicate an effective date. Case Management and Personal Care Attendants are provided by state licensed home health agencies, which may be also Medicare certified. Adult Day Care facilities are also state licensed and have survey oversight. The licenses are renewed yearly by the Office of Healthcare Licensing and Survey. There is close communication between the Aging Division and the Office of Healthcare Licensing and Survey about any licensing issues, survey concerns or complaints about waiver providers. The Waiver Program Manager also receives copies of the post survey letters. Individual qualifications of Case Managers are verified by the Waiver Program Manager and then added to the list of Case Managers under the agencies' provider number.

Meals site evaluations are done yearly by the Aging Division's quality assurance person who works with the individual providers to remediate any identified problems. Problems and concerns that are discovered that are waiver related are reported to the Waiver Program Manager.

The Waiver Program Manager works closely with the Medicaid Program Integrity Unit and the Medicaid Fraud Control Unit and is advised when waiver provider concerns arise. At the present time a waiver provider has been brought to court and pled "No Contest" to a fraud charge. This provider is being closely monitored to determine when sentencing occurs so that the Provider Enrollment can be

voided. In another case in which the Case Manager's paperwork was late or missing on a regular basis, the Medicaid Program Integrity Unit worked closely with the provider presenting her with deadlines for compliance and suspending her Medicaid payments until record reviews were completed and compliance was obtained. Plans are to develop a protocol for monitoring and tracking provider compliance and a system to determine the effectiveness of the interventions.

Case Manager trainings are conducted 5 -6 times a year in different areas of the state and the Aging Division's waiver staff hold a yearly Case Manager's Conference to provide Case Managers an opportunity to network and receive training on resources available to augment the waiver services. One of the sessions is dedicated to waiver issues and further waiver training. A monthly newsletter is also published by the waiver staff and circulated to all providers and interested parties to communicate waiver policy and any new waiver information.

Wyoming has created a new position of Waiver Quality Assurance Specialist to add to the current waiver staff of two, and is in the process of recruiting for that position. Many quality management projects are planned but cannot be fully designed and implemented until the new person is on board. The first project this new position will address is the development of formal provider manual for providers.

4) Health and Welfare

The Aging Division has developed a close working relationship with Adult Protective Services and the Long Term Care Ombudsman on the state level and the Waiver Program Manager in frequent phone contact with both agencies whenever a waiver concern surfaces**.** The new Adult Protection Supervisor is scheduled to speak at the Case Manager Conference in April and is involved in the development of the adult protection packets that will be used for Case Managers to instruct the waiver clients. The Case Managers are encouraged to become part of the local Adult Protection Teams and the local adult protection workers are being instructed to check with the benefits specialists in their local offices to determine if an incoming adult protection report concerns a waiver client so that the Case Manager can be contacted. APS, in partnership with the Aging Division has developed an abuse training kit to assist local APS teams in training their members.

The home health agencies that provide the personal care services are licensed or Medicare certified and complaints are investigated by the Office of Healthcare Licensing and Survey. Concerns are communicated by phone to the Waiver Program Manager but a compilation of all complaints are not available at this time. Plans include a protocol for complaint and incident reporting that will use the processes that the waiver providers already have in place and have a tracking and trending capability. The new tool being developed for reporting by the supervisors of the provider agencies will also collect information about incidents and the resolutions to be transmitted to the Waiver Program Manager quarterly.

5) Administrative Authority

The Aging Division works closely with the Office of Medicaid, especially the Program Integrity Unit. The Waiver Program Manager attends the Medicaid staff meetings, the status meetings held by ACS, the SURS meetings and the Medicaid Office has put together a waiver group that includes all the Wyoming waiver managers. This group meets at least twice a month and explores ways to make the waiver operation and quality assurance efforts as consistent as possible. This relationship will continue to develop into a QA/QI committee as we integrate the new position.

6) Financial Accountability

All waiver Plans of Care are for six (6) months and are prior authorized, by month, and entered into the MMIS preventing payment for services that were not approved. The Plans of Care and the services provided are reviewed at the yearly on-site provider visits. The claims tracking feature that has been added to the data base assists in this function as well as allows tracking for services that have not been provided. Plans include adding 372 reporting to the database so that expenditures can be tracked on a monthly basis.

The Medicaid SURS unit is including waiver claims in their random claims review and the PERM projects and claims that cannot be verified by documentation are recovered, and, when indicated, provider education letters are provided.. The SURS unit is also looking at instances of billing while the waiver client is institutionalized, claims after the date of death, etc. Focused reviews of claims and documentation are initiated when there is an indication of concern about provider practices. The SURS Coordinator has, and continues to participate in provider education opportunities. The waiver newsletter is used to communicate ongoing information about billing and SURS efforts to the providers. Plans to develop and implement a quality assurance/quality improvement manual which will also assist in having written formal procedures to support the SURS efforts. The duties of the new person will include attendance at all SURS meeting and meetings in which SURS protocol is developed.

QMS Element H.2: Roles and Responsibilities

Medicaid Agency

- Assist in determining whether waiver program meets requirements and assurances.
- Assist in development and promulgation of Medicaid rules specific to the Long Term Care Waiver
- Participate in the waiver program Quality Management Committee
- Program Integrity Unit assists with financial accountability assurance.

Waiver Program Management/Staff

- Manage waiver program to meet requirements and assurances by designing and implementing procedures and processes that support the Quality Management Strategy for the waiver program staff, providers and clients.
- Conduct ongoing dialogue with CMS re: waiver operation and QMS
- Monitor reporting systems
- Collect data
- Analyze information
- Share data summary reports with Quality Management Committee, waiver participants, families, advocates, providers, Office of Healthcare Financing, and other state agencies involved with the waiver program, legislators and other interested parties on an identified schedule for report type and focus group
- Facilitate planning of remediation strategies
- Propose, implement, monitor and evaluate improvement initiatives
- Coordinate activities of the Quality Management Committee
- Re-evaluate Quality Management Strategy

Waiver Participants, Families, Advocates

- Provide information and feedback on waiver program procedures and processes from the

recipient side of program services (through interviews, surveys, and informal means)
- Participate in planning remediation strategies and developing improvement initiavives
- Participate in evaluating improvement strategies
- Participate in re-evaluation of Quality Management Strategy
- Membership/representation on Waiver Program's Quality Management Committee

Waiver Providers
- Implement all provider service procedures relating to assessment, service planning, service provision, data collection, documentation, and reporting
- Collect and submit data requested by the waiver program
- Receive and evaluate waiver program summary reports
- Provide feedback on waiver specific procedures and processes to assist in system improvements for participants and providers
- Provide feedback on program's support f providers to assist in system improvements that support development and retention of knowledgeable , stable provider base allowing for client choice for all waiver services
- Participate in planning and implementation of remediation strategies and improvement initiatives
- Assist in monitoring and evaluating improvement initiatives
- Participate in re-evaluation of Quality Management Strategy
- Membership on Program's Quality Management Committee

Other State Agencies – Department of Family Services, Office of Healthcare Licensing and Survey, Community and Family Health
- Receive and evaluate waiver program data summary reports
- Share program information and data specific to elderly and physically disabled served by both programs
- Participate in planning remediation strategies and improvement initiatives
- Assist in monitoring and evaluation of improvements initiatives that impact working relationship between the two agencies
- Membership on Program's Quality Management Committee

Other HCBS Waiver Programs – Division of Developmental Disabilities, Division of Mental Health
- Share Quality Management strategies used by other waiver programs
- Work collaboratively to coordinate quality management strategies when possible
- Share information and evaluates program's data collection and reporting systems
- Share information and evaluate program's data analysis and identified trends
- Provide feedback on remediation proposals and improvement initiatives
- Consult on Quality Management Strategy re-evaluation process
- Membership on Program's Quality Management Committee

QMS Element H.3: Processes to Establish Priorities and Develop Strategies for Remediation and Improvement

The waiver program will establish a Quality Assurance/Quality Improvement Committee to review

and analyze the data collected and establish priorities for remediation strategies and improvement initiatives development and implementation. The organization of this committee is part of the Quality Assurance Specialist position responsibilities that we are currently recruiting for. The anticipated date for the involvement of this committee is 7/1/06. With the formation of the committee processes will be developed to facilitate the scope of work to be done by this group. Remediation strategies and improvement plans for all waiver assurances will be identified to focus on improvements needed, corrective action taken, and initiatives and improvements made to address problems and trends reported through data collection and analysis.

Proposed membership for the Quality Assurance/Quality Improvement Committee will include representatives from:

- Waiver Program Manager
- Waiver Quality Assurance Specialist
- Long Term Care Program Manager
- Developmental Disabilities Program Integrity Manager
- Medicaid Program Integrity Manager
- Medicaid Eligibility Consultant
- Waiver client, family, advocate
- Waiver Service Provider

Proposed focus of Committee work:

- Review and evaluate waiver program's Quality Management Strategy to ensure that procedures and processed support waiver assurances and requirements
- Evaluate data collection procedures and reporting systems and make recommendations for changes and additional data collection areas
- Evaluate data trends and analysis
- Assist in establishing priorities
- Participate in development of remediation strategies and improvement initiatives
- Evaluate improvement initiatives following implementation
- Participate in re-evaluation of Quality Management Strategy

Proposed meeting schedule is quarterly.

QMS Element H.4: Compilation and Communication of Quality Management Information

Waiver Population Reports

To document:

- Demographic information specifics of population being served by waiver program to identify possible trends by diagnosis, age, gender, ethnicity, location, etc.
- Participant satisfaction in program services received to identify processes and procedures for possible change

Reporting frequency:

- Quarterly to Quality Assurance/Quality Improvement Committee, Office of Healthcare Financing Administrator, Aging Division Administrator
- Annual summary and trends also to CMS, Legislators, Department of Health Director, posted on Aging Division website

Waiver Provider Reports

To document:

- Demographic information specific to provider population served by waiver program to identify possible trends by provider types, volume and geographic location
- Performance data focusing on key waiver activities and adherence to provider procedures and identify topics for inclusion in the monthly newsletter

Reporting frequency:

- Quarterly to Quality Assurance/Quality Improvement Committee, Office of Healthcare Financing Administrator, Aging Division Administrator
- Annual Summary and trends also to CMS, Legislators, Department of Health Director, waiver providers and posted to Aging Division website

Plan of Care Reports

To document:

- Key components of Plan of Care development, implementation, and utilization to identify trends in evaluation of overall processes and procedures

Reporting Frequency:

- Quarterly to Quality Assurance/Quality Improvement Committee, Office of Healthcare Financing Administrator, Aging Division Administrator
- Annual Summary and trends also to CMS, Legislators, Department of Health Director, waiver providers and posted to Aging Division website

Incident Reporting Reports

To document:

- Identified issues and trends specific to provider involvement, service planning, and Adult Protection referrals to evaluate overall process and procedures and identify training needs
- Information relating to actions taken, resolution

Reporting Frequency:

- Quarterly to Quality Assurance/Quality Improvement Committee, Office of Healthcare Financing Administrator, Aging Division Administrator
- Annual Summary and trends also to CMS, Legislators, Department of Health Director

Complaint Reporting Reports

To document:

- Identified issues and trends specific to waiver client receiving services, providers and waiver procedures and processes to evaluate service provision, provider capacity, waiver procedures and processes
- Monitoring of assessment and resolution
- Data for consideration of changes and improvements in waiver procedures and processes to identify remediation strategies and improvement initiatives

Reporting Frequency:

- Quarterly to Quality Assurance/Quality Improvement Committee, Office of Healthcare Financing Administrator, Aging Division Administrator, waiver providers
- Annual Summary and trends also to CMS, Legislators, Department of Health Director, waiver providers

Waiting List Reports

To document:

- Length of time on list and disposition to track and trend movement of the list

Reporting Frequency:

- Quarterly to Quality Assurance/Quality Improvement Committee, Office of Healthcare Financing Administrator, Aging Division Administrator, waiver providers
- Annual Summary and trends also to CMS, Legislators, Department of Health Director, waiver providers and posted to Aging Division website

Dispute Resolution and Administrative Hearing Reports

To document:

- Types of situation that prompted requests for dispute resolution and administrative hearings to monitor utilization of dispute resolution process
- Evaluation of success of dispute resolution process in the eliminating the need for administrative hearing

Reporting Frequency:

- Annual summary to Quality Assurance/Quality Improvement Committee, Office of Healthcare Financing Administrator, Aging Division Administrator, CMS, Legislators, Department of Health Director, waiver providers

- **Provider Resources/Client Resource Reports**

To document:

- Development of and updates to provider manuals and resource guides for waiver clients to reflect the implementation of remediation strategies and improvement initiatives and providing historical record of program changes and opportunity to monitor the impact of those changes

Reporting Frequency:

- As changes occur to Quality Assurance/Quality Improvement Committee, Office of Healthcare Financing Administrator, Aging Division Administrator, CMS, waiver clients and providers
- Annual summary to Legislators, Department of Health Director, posted to Aging Division website

QMS Element H.5: Periodic Evaluation and Revision of the Quality Management Strategy

It will be the task of the Waiver Program Manager, Waiver Quality Assurance Specialist and The Quality Assurance/Quality Improvement Committee to perform the annual evaluation and revision of the Waiver Program's Quality Management Strategy. The following work plan has been developed to address this QMS element.

Quality Management Strategy Work Plan

This work plan addresses the following processes yet to be fully developed in the Quality Management Strategy.

QMS Element H.1: Waiver Assurances - Level of Care Determination

Tasks to be Undertaken	Entity/Entities Responsible	Major Milestones
Tracking requests for extensions for Level of Care Evaluations	Waiver Quality Assurance Specialist, Waiver Program Manager	Tracking system in place by 1/1/07

• Develop a log for extension requests • Develop criteria for extensions • Revise LT101 Manual to include criteria Develop data collection system to monitor: • Number of extensions requested • Reason requested • Geographic location of request • Identified problems	Waiver Quality Assurance Specialist Waiver Program Manager Data Base Contractor, Waiver Technology Specialist	LT101 Manual revised by 1/1/07 Data collection system designed and implemented by 2/1/07
Develop method to differentiate between LOC for NF and HCBS	Waiver Quality Assurance Specialist	Method developed by 1/1/07
Develop data collection system to monitor: • Track time between referral and completion of LOC	Data Base Contractor, Waiver Technology Specialist	Data collection system designed and implemented by 2/1/07

QMS Element H.1 Waiver Assurances – Plan of Care

Tasks to be Undertaken	Entity/Entities Responsible	Major Milestones
Develop reporting features from the electronic Plans of Care and the error logs	Data Base Contractor, Waiver Technology Specialist	Reporting features in place by 7/1/06
• Incorporate an "Identified Risk" field on the electronic Plan of Care • Develop method to do trend lines and do comparisons between agencies on the monthly Error Logs sent to the Case Manager agencies	Data Base Contractor, Waiver Technology Specialist	Reporting features in place by 7/1/06
Develop data collection system to monitor • Late renewals • Tracking of "unresolved errors" on Plans of Care • Service utilization	Data Base Contractor, Waiver Technology Specialist	Data collection system designed and implemented by 7/1/06
Develop computerized On-Site Evaluation form, Client Evaluation form, and Agency Documentation form	Waiver Program Manager, Waiver Quality Assurance Specialist, Data Base Contactor	Forms developed and implemented by 7/1/06
• Identify areas of information desired • Identify report elements • Develop policy and procedure for completion of forms • Determine frequency of reporting	Waiver Program Manager, Waiver Quality Assurance Specialist	Forms developed and implemented by 7/1/06
Develop data collection system to monitor: • Agency deficiencies and resolutions • Agency "Best Practices"	Data Base Contractor, Waiver Technology Specialist	Data collection system designed and implemented by

• Client satisfaction • Problem, complaint, dissatisfaction resolution • Agency self-reported utilization of services • Incident tracking		7/1/06

QMS Element H.1 Waiver Assurances – Qualified Providers

Tasks to be Undertaken	Entity/Entities Responsible	Major Milestones
Develop Provider Policy Manual and Program Rules	Waiver Quality Assurance Specialist	Manual
• Gather established policy • Develop format • Interview Waiver Program Manager, Medicaid Program Integrity Manager, MMIS Policy Unit • Compile material into a manual that is easy to read and understand • Arrange printing • Distribute manuals to providers and partners • Post manual to the Aging Division website • Learn state rule making process • Assist with the writing and promulgation of the Waiver rule • Develop protocol for monitoring and tracking compliance to determine effectiveness of interventions with providers	Waiver Quality Assurance Specialist assisted by others as needed	Manual developed and distributed by 7/1/07 Rules promulgated by 1/1/08
Develop data collection system to monitor: • Provider compliance and effectiveness of interventions • Resolutions of provider problems	Data Base Contractor, Waiver Technology Specialist	Data collection system designed and implemented by 1/1/07

QMS Element H.1 Waiver Assurances – Health and Welfare

Tasks to be Undertaken	Entity/Entities Responsible	Major Milestones
Develop packets for APS teaching to clients		
• Work with APS State Consultant and Community Based In-Home Services Program Manager and National Family Caregiver Program Manager to develop protocol and content of packet • Include material on suicide/depression	Waiver Program Manager, APS State Consultant, Community Based In-Home Services Program Manager, National Family	Presentation and training at the 12th Annual LTC/HCBS Case Manager Conference April 20, 2006

provided by the Suicide Prevention Specialist • Arrange for printing of packets • Develop presentation to "kick-off" packets at the 12th Annual Case Manager Conference and provide training for Case Managers • Develop distribution plan to ensure Case Managers for all Aging Division have the packets and training available	Caregiver Program Manager and Suicide Prevention Specialist	
Develop data collection system to monitor: • Training of all new Case Managers • Tracking of information delivery to all waiver clients	Data Base Contractor, Waiver Technology Specialist	Data system designed and implemented by 7/1/06
Develop protocol for complaint and incident reporting	Waiver Program Manager, Waiver Quality Assurance Specialist	
• Research processes that are already in place for licensed providers • Build new protocol to encompass processes already in place • Provide a form for documentation of incident reporting, tracking and resolution • Develop policy and procedure for new documentation • Train providers	Waiver Program Manager, Waiver Quality Assurance Specialist	Protocol developed and implemented by 7/1/06
Develop data collection system to monitor: • Types of incidents, complaints • Timely resolution • Possible trends	Data Base Contractor, Waiver Technology Specialist	Data Collection system designed and implemented by 7/1/06

QMS Element H.1 Waiver Assurances – Financial Accountability

Tasks to be Undertaken	Entity/Entities Responsible	Major Milestones
Develop a Quality Assurance/Quality Improvement Manual	Waiver Quality Assurance Specialist	Manual completed and distributed by 7/1/07
• Research Medicaid requirements • Research Waiver Assurances • Develop format • Compile material into a manual that is easy to read and understand • Post manual to Aging Division website • Make manual available to QA/QI	Waiver Quality Assurance Specialist assisted by others as needed	Manual completed and distributed by 7/1/07

Committee		
Incorporate 372 financial information into the waiver data base	Data Base Contractor	In use by 7/1/06
• Design program access to receive updated paid claim information from the MMIS • Install program on Waiver Program Manager's tablet computer for field use	Data Base Contractor	In use by 7/1/06

QMS Element H.5: Periodic Evaluation and Revision of the Quality Management Strategy

Tasks to be Undertaken	Entity/Entities Responsible	Major Milestones
Develop waiver program Quality Assurance/Quality Improvement Committee • Contact identified agencies for committee representation • Develop quarterly meeting schedule • Share information regarding QMS and focus of committee work	Waiver Program Manager Waiver Quality Assurance Specialist	Establish Quality Assurance/Quality Improvement Committee by 7/1/06
Gather data and report findings for QM Committee review (as outlined in QMS)	Waiver Program Manager	Gather data as outlined in QMS beginning 7/1/06 Report data findings by 12/1/06
Develop and document processes to: • Review QMS Elements H.1 – H.5 • Identify quality management functions • Review relevant data and make recommendations for revisions of data collection processes and procedures • Make recommendations regarding collection of new data elements • Review priorities • Review remediation strategies for each priority • Review improvement initiatives and results of monitoring activities	Waiver Program Manager Waiver Quality Assurance/Quality Improvement Committee members	Develop QMS review process and report identified information by 1/1/07
Document and evaluate results of improvement initiatives	Waiver Program Manager Waiver Quality Assurance/Quality Improvement Committee members	Report results of improvement initiatives by 6/1/07
Develop process to revise QMS	Waiver Program	Revise QMS by

• Establish system to allow historical tracking of revisions • Include communicating changes to stakeholders	Manager Waiver Quality Assurance/Quality Improvement Committee members Participation by groups identified in QMS Element H.2: Roles and Responsibilities	7/1/07 Communicate first year results to stakeholders by 7/31/07
Develop data collection systems to monitor • Those functions as described in QMS Element H.4 and revise as necessary	Data Base Contractor, Waiver Technology Specialist Waiver Quality Assurance Specialist	Ongoing

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

There are various methods the State employs to ensure the integrity of payments for waiver services. The Office of Health Care Financing (Medicaid) has written requirements governing provider audits. A requirement of participation grants Medicaid the authority to conduct routine audits and on-site provider visits. The Office of Health Care Financing has a specific Program Integrity unit that is responsible for overseeing and auditing provider activities. Audits monitor compliance with program requirements. Audits and on-site visits may include, but are not limited to:

- Examination of records
- Interviews of providers, associates, and employees
- Interviews of program clients
- Verification of the professional credentials of providers, their associates, and their employees
- Examination of any equipment, stock, materials and other items used in or for the treatment of program clients
- Audit of facility financial records for reimbursement
- Determination of whether the health care provided is medically necessary and/or
- Random sampling of claims submitted by and payments made to providers

The Program Integrity Unit of the Office of Health Care Financing also ensures the integrity and accuracy of Medicaid payments by utilizing sophisticated information technology that integrates databases containing provider, beneficiary, and claims information. This technology includes the Medicaid Management Information System (MMIS), ad hoc reporting tools, and fraud and abuse software. This auditing process will includes Long Term Care (LTC/HCBS) waiver claims and other claims that process through the MMIS. The auditing of claims is done by random selection as well as select claims which meet certain criteria. The auditing process is done on a periodic basis for utilization review and quality assurance purposes. The Wyoming policies for Medicaid Program Integrity are outlined in the Wyoming Medicaid Rules (Chapters 4 and 16). The Office of Medicaid also participates in the Payment Error Reporting Measurement program to ensure accuracy of the claims reimbursement process.

In addition, the State is required to have independent audits done on an annual basis. These audits include review of payments for services made through the Office of Medicaid. The State Auditor's Office is responsible for conducting the State financial audit program.

In addition, the MMIS maintains required audit trails for all processing. The information is maintained and output may be in a variety of media and formats such as manual logs, imaged copies of documents, and computer-generated process summaries and control totals. Through the life of a claim in the MMIS, the system retains in the claim record all exception codes posting to the claim, the adjudicator ID of the person who forced or denied any exceptions to the claim, and the date and the adjudicator ID of the last

person who worked on the claim. These features provide an audit trail to support the claim's payment process.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The rates for the original waiver application were set to be in alignment with the cost of similar services in the communities. The waivers are now funded by legislative appropriation based on the cost per client in the previous biennium, so any increase in rates is considered by the legislature as exception budget requests. The public is allowed, and encouraged, to express their concerns to their legislators. The Aging Division provides data and our recommendation for rate change through the exception budget request process in the Medicaid budget.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Wyoming Medicaid Management Information System (MMIS) is the system used to accept and process claims for services rendered by the Long Term Care (LTC/HCBS) waiver providers. Providers will directly submit electronic claims using an electronic software system or via web online entry, which are both direct input tools to the Wyoming MMIS. Once a provider submits a claim, the claim enters the MMIS and is processed through the processing cycle, which includes all edits and audits.

The system adjudicates all claims that pass through the MMIS with detailed edit and audit cycle checks (including historical, pre-payment utilization review audits, and duplicate checking) and then pays them during the next payment cycle unless they are to be held for later payment. The claims that fail any of the edits or audits are available to ACS for on-line suspension correction the day following the adjudication cycle where they will be processed to pay or deny.

All claims for a provider are directed to the paid claims file and corresponding records are written to the payment file within the MMIS. Additionally, the system internally assigns a unique transaction control number (TCN) for all of a provider's paid claims. This number is carried in the claim record and appears on the RA. The RA contains paid, denied, and in process claims. RAs are mailed to Wyoming Medicaid providers in hardcopy format or on the web.

The MMIS provides the State with the warrant file following the payment cycle. The payments are made by the WOLFFS system, which is the State system responsible for provider claims payment. Hardcopy warrants are forwarded to ACS for mailing. Electronic warrants are forwarded directly to the provider.

c. Certifying Public Expenditures *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
	☐ **Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐ **Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
X	**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

An individual must be an active Medicaid recipient enrolled in the LTC/HCBS Waiver program in order for services to be processed and paid for. This assurance is an integral component managed by the Wyoming Medicaid Management Information System (MMIS). The MMIS requires an individual to be:

- Enrolled in Medicaid
- Enrolled in a program (in this case, the LTC/HCBS Waiver program)

Additional checks regarding services rendered, including appropriate provider type, no duplicate claims submitted, etc. are also performed.

The Wyoming Claims Processing Subsystem uses a Recipient Master File to verify recipient eligibility for services billed by a provider. Once an individual becomes eligible for services, the client's eligibility information is updated in the MMIS. Only services in the client's plan will be covered based on limits established by the prior authorization number assigned to the service. When the recipient is eligible for multiple benefit plans concurrently, the recipient eligibility process uses the State defined plan processing hierarchy to eliminate, in sequence, any benefit plan that does not cover the services on the claim or claim line. The MMIS posts exceptions if a recipient is not eligible on the service date or is restricted from the service (as indicated in the service restrictions on the Recipient Master File). Service restrictions may include restricting the recipient to a particular provider for treatment or placing the recipient on review.

The MMIS checks other service limitations by referencing recipient Medicaid eligibility, TPL, and by various benefit plan specific limits established by the Utilization Review (UR) Criteria File.

Each claim processed by the Wyoming Claims Processing cycle (regardless of the entry method) has to pass the provider eligibility edit module. The Provider Master File verifies that the provider is actively enrolled and licensed according to the benefit plan for the category of service and dates of service. It also verifies any special restrictions for the provider for the service date on the claim. For each test that fails, the MMIS posts an exception code. The claim is adjudicated according to the exception disposition codes maintained on the Exception Control File.

The Claims Processing Subsystem also uses several edits to verify the reasonableness of provider charges. First the system performs internal balancing of claim charges. Second, the system edits and checks each service charge against pricing information on the reference files.

The Office of Medicaid determines the disposition of the exception codes posting to claims and the system maintains this information on line in the Exception Code File. The Claims Processing Subsystem has the capability of allowing the force payment of services on an exceptional basis, as directed in writing by the Office of Medicaid.

Through the life of a claim, the system retains in the claim record all exception codes posting to the claim, the adjudication ID of the person who forced or denied any exceptions to the claim, and the date and adjudication ID of the last person who worked on the claim. These features provide an audit trail to support the claim's payment process.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

X	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

☐	The Medicaid agency makes payments directly to providers of waiver services.
X	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	**No**. The State does not make supplemental or enhanced payments for waiver services.
O	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

X	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
	Public Health Agencies
O	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

X	The amount paid to public providers is the same as the amount paid to private providers of the same service.
O	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
O	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

X	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
O	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
O	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

O	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
X	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

O	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
X	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

X	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
X	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
X	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

X	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
X	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

X	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

	Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$9,313	$7, 722	$17,035	$24,800	$5,933	$30,733	$13,698
2	$,9,737	$8,200	$17,937	$25,100	$6,150	$31,250	$13,313
3	$9,970	$8,350	$18,320	$25,250	$6,200	$31,450	$13,130
4	$10,136	$8,500	$18,636	$25,350	$6,350	$31,700	$13,064
5	$10,285	$9,000	$19,285	$25,450	$6,450	$31,733	$12,448

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	1450		
Year 2	1450		
Year 3	1450		
Year 4 (renewal only)	1450		
Year 5 (renewal only)	1450		

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

Based on the history of this waiver, it is estimated that the average length of stay will be 290 days

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates are based on information from the 372 report.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates are based on information from the 372 report.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates are based on information from the 372 report.

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates are based on information from the 372 report.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	Day	965	290	$7.87	$2,202,420
Care Coordinator	Day	232	305	$5.36	$379,274
Personal Care Attendant	15 minutes	920	800	$3.75	$2,760,000
Self-Help Assistant	15 minutes	232	3800	$2.25	$1,983,600
Financial Management Services	Per month	232	12	$129.44	$360,361
Adult Day Care	15 minutes	100	2000	$2.00	$400,000
PERS (installation)	1 install	150	1	$70.00	$10,500
PERS (monthly	1 per month	900	12	$45.00	$486,000
Skilled Nursing	1 hour	450	75	$30.00	$1,012,500
Home-Delivered Meals	Meal	950	300	$5.00	$1,425,000
Respite Care	15 minutes	50	550	$3.25	$89,375
Non-Medical Transportation	One-way trip	225	85	$2.00	$38,250
GRAND TOTAL:					$11,147,280
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1197
FACTOR D (Divide grand total by number of participants)					$9313
AVERAGE LENGTH OF STAY ON THE WAIVER					290 days

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	Day	980	293	$7.87	$2,259,792
Care Coordinator	Day	240	308	$5.36	$396,211
Personal Care Attendant	15 minutes	923	826	$3.75	$2,858,993
Self-Help Assistant	15 minutes	240	3850	$2.25	$2,079,000
Fiscal Management Services	Per month	240	12	$129.44	$372,787
Adult Day Care	15 minutes	124	2200	$2.00	$545,600
PERS (installation)	1 install	160	1	$70.00	$11,200
PERS (monthly	1 per month	930	12	$45.00	$502,200
Skilled Nursing	1 hour	475	80	$30.00	$1,140,000
Home-Delivered Meals	Meal	960	325	$5.00	$1,560,000
Respite Care	15 minutes	60	576	$3.25	$112,320
Non-Medical Transportation	One-way trip	230	90	$2.00	$41,400
GRAND TOTAL:					$11,879,503
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1220
FACTOR D (Divide grand total by number of participants)					$9,737
AVERAGE LENGTH OF STAY ON THE WAIVER					293 days

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	Day	995	294	$7.87	$2,302,211
Care Coordinator	Day	245	309	$5.36	$405,778
Personal Care Attendant	15 minutes	950	840	$3.75	$2,992.500
Self-Help Assistant	15 minutes	245	3875	$2.25	$2,136,094
Fiscal Management Services	Per month	245	12	$129.44	$380,554
Adult Day Care	15 minutes	130	2300	$2.00	$598,000
PERS (installation)	1 install	165	1	$70.00	$11,500
PERS (monthly	1 per month	940	12	$45.00	$507,600
Skilled Nursing	1 hour	480	85	$30.00	$1,224,000
Respite Care	15 minutes	62	580	$3.25	$116,870
Home-Delivered Meals	Meal	965	340	$5.00	$1,640,500
Non-Medical Transportation	One-way trip	236	100	$2.00	$47,200
GRAND TOTAL:					$12,362,807
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1240
FACTOR D (Divide grand total by number of participants)					$9970
AVERAGE LENGTH OF STAY ON THE WAIVER					294 days

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	Day	1002	294	$7.87	$2,318,408
Care Coordination	Day	252	310	$5.36	$418,723
Personal Care Attendant	15 minutes	975	850	$3.75	$3,107,812
Self-Help Assistant	15 minutes	252	3900	$2.25	$2,211,300
Fiscal Management Services	Per month	252	12	$129.44	$391,427
Adult Day Care	15 minutes	132	2320	$2.00	$612,480
PERS (installation)	1 install	165	1	$70.00	$11,500
PERS (monthly	1 per month	945	12	$45.00	$510,300
Skilled Nursing	1 hour	485	88	$30.00	$1,280,400
Respite Care	15 minutes	65	600	$3.25	$126,750
Home-Delivered Meals	Meal	970	345	$5.00	$1,673,250
Non-Medical Transportation	One-way trip	238	100	$2.00	$47,600
GRAND TOTAL:					$12,709,950
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1254
FACTOR D (Divide grand total by number of participants)					$10,136
AVERAGE LENGTH OF STAY ON THE WAIVER					294 days

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	Day	1010	295	$7.87	$2,344,866
Care Coordinator	Day	260	310	$5.36	$432,016
Personal Care Attendant	15 minutes	985	856	$3.75	$3,161850
Self-Help Assistant	15 minutes	260	3920	$2.25	$2,293,200
Fiscal Management Services	Per month	260	12	$129.44	$403,853
Adult Day Care	15 minutes	135	2330	$2.00	$629,100
PERS (installation)	1 install	167	1	$70.00	$11,690
PERS (monthly	1 per month	948	12	$45.00	$511,920
Skilled Nursing	1 hour	488	90	$30.00	$1,317,600
Respite Care	15 minutes	70	626	$3.25	$142,415
Home-Delivered Meals	Meal	978	360	$5.00	$1,760,400
Non-Medical Transportation	One-way trip	240	110	$2.00	$52,800
GRAND TOTAL:					$13,061,710
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1270
FACTOR D (Divide grand total by number of participants)					$10,285
AVERAGE LENGTH OF STAY ON THE WAIVER					295 days

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers. Complete the following table for each waiver year.

Waiver Year: Year 1						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Request for Evidentiary-Based Information

Level of Care Determination

Evidence that:

- An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
- Enrolled participants are reevaluated at least annually or as specified in its approved waiver.
- The process and instruments described in the approved waiver are applied to determine LOC.
- The state monitors level of care decisions and takes action to address inappropriate level of care determinations.

Examples:

Reports from state monitoring reviews conducted; a summary report of all reviews; minutes of committee meetings showing evaluation of findings and recommendations and strategies for improvement developed. Do not submit policies, procedures, forms or individual participant records.

Plan of Care

Evidence that:

- POCs address all participant's assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
- The state monitors POC development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of POCs.
- POCs are updated/revised when warranted by changes in the waiver participant's needs
- Services are specified by type, amount, duration, scope and frequency and are delivered in accordance with the POC.
- Participants are afforded choice:
    1) between waiver services and institutional care
    2) between/among waivers services and providers

Examples:

Reports from state monitoring reviews of POCs; reports of monitoring of service refusal and analysis; reports of state monitoring (e.g., provider, county, case management) to verify that services in POC have been received; summary report of all reviews; minutes of committee meetings showing evaluation of findings, recommendations and corrective actions taken and strategies for improvement developed; results of feedback from participant interviews or focus groups; analysis of incident reports/complaints; analysis of reported incidents; results of focus group meetings; results of staff interviews. Do not submit policies, procedures, forms or individual participant records.

Qualified Providers

Evidence that:

- The state verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards.
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- The state identifies and rectifies situations where providers do not meet requirements.
- The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

Examples:

Reports from state monitoring; minutes of committee meetings showing evaluation of findings and recommendations related to provider qualifications and training; actions taken when deficiencies are identified such as sanctions or correspondence; reports include both licensed providers and those qualified through other means; analysis of complaints or incident reports; documentation of TA/training sessions. Do not submit policies, procedures, forms, qualification standards or provider records.

Health and Welfare

Evidence that:

- The state, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.

Examples:

Ongoing monitoring reports; reports and analysis of complaints; reports and analysis of allegations of abuse neglect and exploitation; results of investigations and actions taken; reports and action taken on plan of care discrepancies; minutes of QA or other committee meetings that show review of monitoring, recommended actions and follow-up reports. Do not submit policies, procedures, forms or individual participant records.

Administrative Authority

Evidence that:

- The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.

Examples:

A description of the state quality management program with evidence of activity such as monitoring and review reports; committee minutes; a record of actions taken; record of service denials and appeal requests; copies of issued notices of appeal.

Financial Accountability

Evidence that:

- State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

Examples:

Audit reports; monitoring reports; management meeting minutes that reflect analysis, recommendations and actions.